NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
EMERGENCY MEDICAL SERVICES PROGRAM
APPLICATION FOR TRAUMA CENTER REVIEW AND DESIGNATION

In accordance with the requirements of the Nebraska Statewide Trauma System Act (Neb. Rev. Stat. §§ 71-8201 – 71-8253 (1997) and the Nebraska Statewide Trauma System Regulations (185 NAC) application is hereby made for review and designation as a trauma center.	**DESIGNATION LEVEL OR CONSULTATION REQUESTED (√)** **Basic** ☐ **General** ☐ **Advanced** ☐ **Comprehensive** ☐ **Consultation** ☐

HOSPITAL INFORMATION – Section A

Name of Hospital (Name to Appear on Designation Certificate)		Telephone Number
Address (Street and Number)	(City)	(Zip)

PROFESSIONAL INFORMATION – Section B

Chief Executive Officer	Chairman/President of Board of Trustees
Physician in Charge of Trauma Care	Trauma Program Manager
Director of Emergency Medicine	Contact Person and Phone Number

RESOURCE INFORMATION – Section C

1. E.D. Trauma Admissions	2. E.D. Trauma Admissions Transferred to Another Hospital	3. C.T. Scan Capability	4. Hospital Beds
5. Operating Rooms	6. ICU/CCU Beds	7. Surgeons	8. ED Physicians
9. Anesthesiologists	10. CRNAS		

CERTIFICATION – Section D

DATE OF APPLICATION	**SIGNATURE OF HOSPITAL CHIEF EXECUTIVE OFFICER**
SIGNATURE OF TRAUMA DIRECTOR OR CHIEF OF STAFF	

Instructions for Completion of Application For Trauma Center Review and Designation or Consultation.

Section A-D describes how to complete the attached application form for trauma center review and designation or consultation. Please do not leave any boxes blank (unless you are applying for consultation at this time). Boxes left blank on the application form will be interpreted as an incomplete application. If a box does not apply, please indicate "None".

Designation Level or Consultation Requested

Designation
Indicate whether the hospital is applying for designation as a Basic, General, Advanced or Comprehensive Level Trauma Center.

Consultation
If you need additional information prior to applying for designation, please indicate "Consultation", complete Sections A-C to the best of your knowledge, submit the incomplete application and you will be contacted. Please be certain to indicate a contact name and phone number in Section B for a person to contact about the consultation. *Section D does not need to be completed at this time if you are requesting a consultation.*

HOSPITAL INFORMATION - SECTION A

Name of Hospital
Type the name of the hospital as it should appear on the designation certificate.

Telephone Number
Type the telephone number including area code for the administrative offices of the hospital.

Address
Type the street address of the hospital, including city and zip.

PROFESSIONAL INFORMATION - SECTION B

Chief Executive Officer
Type the name of the Chief Executive Officer (Corporate CEO).

Chairman/President of Board of Trustees
Type the name of the Chief Officer of the Hospital Board of Directors.

Physician in Charge
Type the name of the Trauma Medical Director, including MD or DO.

Trauma Program Manager
Type the name of the Trauma Program Manager or nurse who fulfills those duties.

Director of Emergency Medicine
Type the name of the physician director of the emergency department, including MD or DO.

Contact Person and Phone Number
Provide the name and phone number of the person to contact for questions about the application.

RESOURCE INFORMATION – SECTION C

1. E.D. Trauma Admissions

Indicate the *approximate* number of E.D. admits for any injury admissions seen in the hospital emergency department for the twelve months immediately proceeding the month of application. Include all injuries for the estimate.

2. E.D. Trauma Admissions Transferred to Another Hospital

Indicate number of E.D. admits seen in the hospital emergency department for the twelve months immediately proceeding the month of application that were transferred to another hospital. Include all transfer injuries for the estimate.

3. C.T. Scan Capability

If the hospital has an in-house C.T. Scanner that is staffed by in-house personnel 24-hours per day, everyday, indicate FULL as the level of capability.

If the hospital has an off-campus C.T. Scanner, or one that is not staffed by in-house personnel 24- hours per day, everyday, indicate PARTIAL as the level of capability.

If the hospital has no C.T. Scanner, indicate NONE as the capability.

4. Hospital Beds

Indicate the total number of hospital beds at the hospital.

5. Operating Rooms

Indicate the total number of operating rooms that are used for *trauma* patients at the hospital.

6. ICU/CCU Beds

Indicate the total number of intensive care beds available for *trauma* patients at the hospital.

7. Surgeons

Indicate the total number of general surgeons that take general surgery call at the hospital.

8. ED Physicians

Indicate the total number of physicians participating in Emergency Department care at the hospital.

9. Anesthesiologists

Indicate the total number of anesthesiologists that take anesthesia call at the hospital.

10. CRNA's

Indicate the total number of Certified Registered Nurse Anesthetists that take CRNA call at the hospital.

CERTIFICATION – SECTION D

Indicate date and year the application is submitted.

Submit signatures as indicated on the application.